PRINTED: 06/13/2011 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		155784	B. WIN				C 8/2011
	OVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS ROAD MISHAWAKA, IN 46545	1 06/0	6/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	This visit was for the IN00090918.	Investigation of Complaint					
		unction with the PSR (Post Investigation of Complaint ed on 4/27/11.					
	Complaint IN0009099 Federal/State deficient allegations are cited a						
	Survey Dates: June	7 and 8, 2011					
	Provider number:	012329 155784 201002500					
	Surveyor: Antoinette Krakowski	, RN					
	Census bed type: NF: 32 SNF/NF: 46 Total: 78						
	Census payor type: Medicare: 46 Medicaid: 14 Other: 18 Total: 78						
	Sample: 3						
	These deficiencies al accordance with 410	so reflect State findings in IAC 16.2.					
	Quality review comple	eted 6/10/11					
A BODATORY	DIDECTOR'S OR PROVIDER!	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITI F		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		455704					C
		155784				06/0	8/2011
	ROVIDER OR SUPPLIER A HEALTH AND REHABIL	ITATION CENTER		14	REET ADDRESS, CITY, STATE, ZIP CODE 420 E DOUGLAS ROAD MISHAWAKA, IN 46545		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	Cathy Emswiller RN			000			
F 221 SS=D	483.13(a) RIGHT TO PHYSICAL RESTRAI		F	221			
	physical restraints imp	right to be free from any cosed for purposes of nce, and not required to edical symptoms.					
	by: Based on observation review, the facility fail kept free from restrair of a floor mat to keep rising and freely movi	n, interview, and record ed to ensure a resident was nts related to the facility use a dementia resident from ng about the facility for 1 of for restraints in a sample of					
	Resident: #C						
	Findings include:						
	A.M., while accompar Director of Nursing), s had dementia and wa alarms on her wheel of history of falls. Reside	ne facility on 6/07/11 at 9:05 hied by the ADON (Assistant she indicated Resident #C s equipped with personal chair and bed because of a ent #C was seated in the at the time of the initial tour.					
	6/07/11 at 2:50 P.M. a	record was reviewed on and indicated diagnoses of, nentia, a history of urinary and a history of falls.					
	Review of Nurse's Pro	ogress Notes, dated 5/19/11,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF	
		155784			·		0
	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS ROAD MISHAWAKA, IN 46545	06/0	8/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 221	Chair alarm on. Got uto walk. Intervened jutall. Very unsteady on P.MAgain making sequnassisted6:15 P.M assisting resident to famb (ambulating) 8 fe Staggering gait. Again fall7:10 P.MAgain fall-mat. Watching ga During interview with 6/07/11, she indicated the fall-mat in the day busy and didn't know wouldn't fall and sustajob fair in the facility the floor mat because position." When querifrom the floor mat with stated, "She could not The quarterly MDS (M. Assessment, dated 5. #C was not steady and seated to standing posurface transfer with lindicated she was modecision-making. A Care Plan titled "Fa Prevention and Manainitiated 2/22/11 and under the proposition of the province of	"Up in W/C (wheel chair). p from W/C and attempted st as pt (patient) about to feet-leads with head5:15 everal attempts to get up lCame out of room from ind (Resident #C) up and eet from unlocked W/C. n, intervened before up-eased to floor on me show. Fluids at hand" LPN #2 at 4:40 P.M. on d she placed Resident #C on room because she was so what to do with her so she ain an injury. "There was a hat evening and I was risor to put Resident #C on e she couldn't fall from that ed if Resident #C could rise mout assistance, LPN #2 t." Minimum Data Set) /30/11, indicated Resident ind could only rise from a sition and surface to numan assistance. It further inderately impaired for	F	221			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUF	
		155784	B. WIN				0
	ROVIDER OR SUPPLIER	L		14	EET ADDRESS, CITY, STATE, ZIP CODE 420 E DOUGLAS ROAD 1ISHAWAKA, IN 46545	06/0	8/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 221	if a fall would occur activity-lg (large) puzz (initiated 2/25/11)" An IDT (Inter-disciplir dated 3/30/11, indicar without injury. Immed diversional activity; ac (regarding) need for i boredom" During continued inte 6/07/11 at 4:40 P.M., #C puts the puzzle to then bored with it. "S occupy her. I take he time, but other than tl Room or at the Nurse provide a one on one The Director of Nursi on 6/08/11 at 4:00 P.I into a "busy box" of s #C some additional ty A facility policy titled " Restrictive," revised a "Policy:Restraining safety device (physic manual method or ph device, material, or e adjacent to the reside freedom of movemen body"	Il be free of a serious injury Interventions: Diversional zlebed and chair sensors ary Team) Progress Note, red, "recent fall 3/29/11 iate intervention was ctivities notified rencreased activity to alleviate rview with LPN #2 on she indicated that Resident gether in five minutes and is he needs other things to for a walk when I have nat, she sits in the Day is station where we can observation of her." Ing indicated in an interview M., the facility would check ome sort to offer Resident res of activities. Safety Device-Least lanuary 2011, indicated, Safety Device: A restraining all restraint) is defined as any ysical or mechanical safety	F	221			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION	(X3) DATE SU COMPLET	
			A. BUIL	.DING			С
		155784	B. WIN	G)8/2011
	OVIDER OR SUPPLIER	BILITATION CENTER		1420	ADDRESS, CITY, STATE, ZIP CODE E DOUGLAS ROAD HAWAKA, IN 46545	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 221 F 241 SS=D	Continued From page 3.1-3(w) 483.15(a) DIGNITY INDIVIDUALITY			221 241			
	manner and in an e enhances each resi	omote care for residents in a nvironment that maintains or dent's dignity and respect in s or her individuality.					
	by: Based on observat review, the facility fa dignity was upheld i her on a floor mat ir keep her from rising	ion, interview, and record ailed to ensure a resident's related to the facility placing a the Day Room of the unit to and freely moving about the idents reviewed for restraints					
	Resident: #C						
	A.M., while accomp Director of Nursing) had dementia and v alarms on her whee history of falls. Resi Day Room of her ur Resident #C's clinic 6/07/11 at 2:50 P.M	the facility on 6/07/11 at 9:05 anied by the ADON (Assistant , she indicated Resident #C was equipped with personal chair and bed because of a dent #C was seated in the nit at the time of the initial tour. al record was reviewed on and indicated diagnoses of, ementia, a history of urinary				COMPLETE C 06/08 RECTION SHOULD BE	
	tract infection (UTI),	and a history of falls. Progress Notes, dated 5/19/11,					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF	
		155784					0
	ROVIDER OR SUPPLIER	L		1	REET ADDRESS, CITY, STATE, ZIP CODE 420 E DOUGLAS ROAD MISHAWAKA, IN 46545	1 06/0	8/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 241	Chair alarm on. Got uto walk. Intervened jutall. Very unsteady on P.MAgain making so unassisted6:15 P.M assisting resident to famb (ambulating) 8 fc Staggering gait. Again fall7:10 P.MAgain fall-mat. Watching ga During interview with 6/07/11, she indicated the fall-mat in the day busy and didn't know wouldn't fall and sustagiob fair in the facility tadvised by my supervite floor mat because position." When querifrom the floor mat wit stated, "She could not The quarterly MDS (Massessment, dated 5 #C was not steady ar seated to standing posurface transfer with indicated she was modecision-making. A Care Plan titled "Fa Prevention and Manainitiated 2/22/11 and in "Assessment:Cogn Dementia-does not all	"Up in W/C (wheel chair). Ip from W/C and attempted st as pt (patient) about to a feet-leads with head5:15 everal attempts to get up and the control of	F	241			

STATEMENT OF DEFICIE AND PLAN OF CORRECT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		155784	B. WIN				0/2044
NAME OF PROVIDER OF				14	REET ADDRESS, CITY, STATE, ZIP CODE 420 E DOUGLAS ROAD MISHAWAKA, IN 46545	1 06/0	8/2011
	EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
awaren if a fall activity- (initiate An IDT dated 3 without diversic (regard boredor During 6/07/11 #C puts then be occupy time, bu Room of provide The Dir on 6/08 into a "I #C som This fee 3.1-3(t) 483.15(t) SS=D INTERIOR The factor of activity the content of the phy	would occur Ig (large) puz d 2/25/11)" (Inter-discipli /30/11, indica injury. Immediate inal activity; a ing) need for m" continued inter at 4:40 P.M., the puzzle to red with it. "S her. I take he at other than to a one on one ector of Nursi /11 at 4:00 P. busy box" of s ine additional to deral tag relat If (1) ACTIVIT ESTS/NEEDS ility must provities designed apprehensive a	fill be free of a serious injury Interventions: Diversional Izlebed and chair sensors mary Team) Progress Note, Ited, "recent fall 3/29/11 Idiate intervention was Ictivities notified re Increased activity to alleviate erview with LPN #2 on Ishe indicated that Resident Ingether in five minutes and is Ishe needs other things to Iter for a walk when I have Iter hat, she sits in the Day Iter set station where we can Iter observation of her." Ing indicated in an interview Ing i		241			

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		155784	B. WIN	G			C 8/2011
	ROVIDER OR SUPPLIER	LITATION CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 420 E DOUGLAS ROAD MISHAWAKA, IN 46545		<i></i>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 248	by: Based on observation review, the facility fail dementia and a histon diversionary activities resident for 1 of 3 defor activities in a same Resident: #C Findings include: During initial tour of the A.M., while accompand Director of Nursing), shad dementia and water alarms on her wheel whistory of falls. Resident was alarms on her united Resident #C's clinical 6/07/11 at 2:50 P.M. abut not limited to: derivation faction (UTI), and resident #C had sus 2/28/11, 3/29/11, and room. The quarterly MDS (Massessment, dated 5 #C was moderately in the same and the faction of the same and the faction of	is not met as evidenced n, interview, and record ed to ensure a resident with ry of falls was provided to meet the needs of the mentia residents reviewed ple of 3. ne facility on 6/07/11 at 9:05 nied by the ADON (Assistant she indicated Resident #C as equipped with personal chair and bed because of a ent #C was seated in the at the time of the initial tour. record was reviewed on and indicated diagnoses of, nentia, a history of urinary and a history of falls. ogress Notes indicated tained a fall on 2/25/11, 5/28/11 while outside her Minimum Data Set) /30/11, indicated Resident npaired for decision-making, e needed extensive assist of	F	248			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	
		155784	B. WIN	IG		06/0	B/ 2011
	ROVIDER OR SUPPLIER	LITATION CENTER	I	1	REET ADDRESS, CITY, STATE, ZIP CODE 420 E DOUGLAS ROAD MISHAWAKA, IN 46545	00/00	5/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 248	initiated 2/22/11 and a "Assessment:Cogn Dementia-does not al light/ask for assist to awarenessIntervent (large) puzzle (initiated An IDT (Inter-discipling dated 3/30/11, indicated without injury. Immed diversional activity; and (regarding) need for iboredom" During observation of she was observed sitt Room across from the time of the initial tour toileted and taken to observed sitting along at 1:45 P.M. A staff provending machine in the with LPN #3 at 2:45 F. #C had attended an inwith other residents. It was again observed in Room across from the unopened puzzle box near where she was a forward in her wheel residents in the Day F summoned for fear R her wheel chair. LPN to the Nurse's Station	all/Injury Assessment: agement Plan of Care," updated 5/30/11, indicated, aitive Impairment factors: lways remember to use call aget updecreased safety ations: Diversional activity-lg ad 2/25/11)" hary Team) Progress Note, and, "recent fall 3/29/11 ate intervention was activities notified re acreased activity to alleviate a Resident #C on 6/07/11, ating at a table in the Day a Nurse's Station from the (9:05 A.M.) until she was at a table in the facility cafe berson was observed near a and cafe. During interview and A.M., she indicated Resident are cafe. During interview and A.M., Resident #C and her wheel chair in the Day and Nurse's Station. An are was observed on the table astiting. She was leaning achair; there were no other	F	248			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE SUF COMPLET	
			B. WIN	LDING IG		1	С
		155784				06/0	8/2011
	ROVIDER OR SUPPLIER A HEALTH AND REHABI	LITATION CENTER		1420	T ADDRESS, CITY, STATE, ZIP CODE DE DOUGLAS ROAD HAWAKA, IN 46545		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 248	afternoon until 4:20 fdown the hall for a q the facility. Staff wow while she was sitting. During interview with P.M., she indicated the puzzle together in five with it. "She needs of take her for a walk with that, she sits in Nurse's station where one observation of his two activity staff, but and she was very but other residents she refor. "I wondered if she book and crayons to the Director of Nurson 6/08/11 at 4:00 Pinto a "busy box" of state of the program," dated Jan Extendicare Health Stoprovide meaning for individualized activities are in our Extendicor more activities and dayindividualized gattend multi-participation.	P.M. when staff wheeled her uick tour to the front lobby of ald occasionally address her at the Nurse's Station desk. LPN #2 on 6/07/11 at 4:40 hat Resident #C puts the eminutes and is then bored other things to occupy her. I hen I have time, but other the day room or at the ew can provide a one on er." She indicated there are only one was in (6/07/11) sy because there were many needed to provide activities ewouldn't enjoy a coloring help keep her busy." Ing indicated in an interview M., the facility would check some sort to offer Resident ypes of activities. "Extendicare Life Enrichment uary 2009, indicated, "Policy: Services, Inc. (EHSI) goal is all recreational and es to the residents who we care centersStandards:5 allable per programs for those not able to	F	248			